



Letter to the Editor

Performing sleeve gastrectomy

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Surgical technique
Sleeve gastrectomy
Coelioscopy
Greater curve
Leak test
Gastrectomy specimen

Sleeve gastrectomy is a restrictive bariatric operation that has become popular as a way to achieve weight loss [1]. The enthusiasm for sleeve gastrectomy is explained by its advantages and good medium term results, both in terms of weight loss and comorbidities. However, there are a few technical controversies which explain why there is no standardised technique in 2014. The aim of this article is to describe the tips and tricks for this technique. We shall also discuss the controversial subjects.

1. Points of controversy: approach to release of the greater curve

Two techniques have been described: either from outside inwards, with initial release of the greater curve before dividing the stomach, or from inside outwards, beginning with the gastric division first before releasing the greater curve [2]. The second technique is more difficult as working space is reduced. The ease of this procedure at this level depends on the length of the short vessels and the patient's BMI (Body mass index).

2. Points of controversy: extent of inferior dissection of the greater curve

The end of the inferior dissection is controversial as the antrum is divided between 2 and 7 cm from the pylorus, depending on the surgical team [3]. Beginning the division at 6–7 cm from the pylorus leaves more antrum which is believed to reduce the pressure in the gastric tube, allowing better gastric emptying. Dividing the stomach 2 cm from the pylorus increases the restriction, but also increases the risk of stenosis at the angle of the lesser curve, and increases pressure in the tube, which is considered by some experts as a high risk factor for developing a gastric fistula [4]. The difficulty with this dissection is also due to the fact that the descriptive anatomy of the gastrointestinal tract is based on anterior views, whereas during a sleeve gastrectomy the dissection is posterior and the anatomy is therefore less familiar to the surgeon [5].

3. Points of controversy: leak testing of the anastomosis

An air and/or methylene blue test is recommended with the

gastric tube positioned in the lower oesophagus and the antrum clamped [6]. Approximately 120 cc of liquid or air is used under pressure. Note that it is essential to tell the anaesthetist to inject the methylene blue or air into the tube and not into the balloon, as there is a risk of the swollen balloon damaging the lower oesophagus. There is a difference among surgeons regarding the leak test they use, with some performing one and others performing both [6,7]. Less commonly, an endoscopic control is performed to check if there is no bleeding, leaks or stenosis [8,9]. Regardless of the method used, a negative test does not guarantee that there will be no postoperative complications, including fistulae. For this reason, some groups do not carry out the test [10].

4. Points of controversy: specimen extraction

The specimen is extracted into a bag through the 15 mm opening. In order to facilitate extraction, a stitch or knot may be placed around the narrowest end of the resected specimen and cut long, so that its end comes out of the bag. It is then easier to find the stomach and extract it by gentle traction movements. It is recommended to close all the defects of the trocars over 10 mm. If the abdominal wall is not thick, the specimen can be extracted through a 12 mm opening instead of a 15 mm opening.

5. Points of controversy: routine testing of the resected stomach. Is it really necessary?

After having carefully extracted the stomach, we inflate it with air using a regular syringe until it is well filled. This tip could highlight a potential defect of the stapling line [11]. A removed gastric volume of <500 cc seems to be a predictor of failure in treatment or early weight regain [12]. The specimen should always be sent for histological examination (to identify a tumour not noticed in the preoperative gastroscopy) and for *Helicobacter pylori* (even if routine testing was negative preoperatively).

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Radwan KASSIR: writing.

Pierre Blanc: conceptualized and designed the paper.

Patrice Iointier: data collections.

Imed Ben Amor, Elias Bachir, Tarek Debs and Jean Gugenheim:
reviewed the paper.

Olivier Tiffet: reviewed and revised the paper.

Conflict of interests

None.

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Radwan Kassir*

Department of General Surgery, CHU Hospital, Jean Monnet
University, Saint Etienne, France

Tarek Debs

Department of Bariatric Surgery, Archet 2 Hospital, University
Hospital of Nice, Nice, France

Pierre Blanc

Department of Digestive Surgery, Clinique Chirurgicale Mutualiste de
Saint-Etienne, France

Jean Gugenheim

Department of Bariatric Surgery, Archet 2 Hospital, University
Hospital of Nice, Nice, France

Patrice Lointier

Department of Digestive Surgery, Clinique de la châtaigneraie,
Beaumont, France

Elias Bachir

Department of Digestive Surgery, Centre Hospitalier Régional Metz-
Thionville, Thionville, France

Imed Ben Amor

Department of Bariatric Surgery, Archet 2 Hospital, University
Hospital of Nice, Nice, France

Olivier Tiffet

Department of General Surgery, CHU Hospital, Jean Monnet
University, Saint Etienne, France

* Corresponding author. Department of General Surgery, CHU
Hospital, Jean Monnet University, Avenue Albert Raimond, 42270
Saint Etienne, France.

E-mail address: radwankassir42@hotmail.fr (R. Kassir).

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